



# PUBLIC HEALTH BRIEFING

RHODE ISLAND DEPARTMENT OF HEALTH

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## RHODE ISLAND'S CHILD DEATH REVIEW TEAM

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The death of a child is a singularly tragic event. Especially tragic is a death that could have been prevented.

Originally child death review teams were established to identify and to prevent child deaths caused by abuse and neglect. However, like a number of other states, Rhode Island has opted for a broader review process that addresses all preventable child deaths from a public health perspective. This approach not only addresses maltreatment-related deaths but also promotes better understanding and greater awareness of all the causes of child deaths.

### HISTORY

In 1998 the Rhode Island Department of Children, Youth and Families (DCYF) established the Rhode Island Child Death and Injury Review Team (RICDIRT) to review deaths and serious injuries of children in the state. In 2004, the RICDIRT responsibilities were divided. The review of fatalities became the responsibility of the Rhode Island Child Death Review Team, organized under the Rhode Island Medical Examiners Office. Beginning with the review of calendar year 2000 child deaths, the Chief Medical Examiner has coordinated the Rhode Island Child Death Review Team.

### MISSION AND GOALS

The RICDIRT is committed to the systematic multidisciplinary comprehensive review of child deaths. It is designed to provide detailed information beyond that available from analysis of death certificates alone. These findings can be used by community-based partners, legislators, and public policy makers to take action to prevent other deaths and improve the safety and well-being of all children. The ultimate goal of the team is to reduce the number of child deaths in the state.

### OPERATION OF CHILD DEATH REVIEW TEAMS

Child fatality team members represent many disciplines, including investigation, healthcare, or other service delivery.<sup>1,2</sup>

Even team members that might not consider themselves to be in a preventive role contribute to the identification of potentially premature death. For example, law enforcement officers know the causes of motor vehicle crashes. Prosecutors understand the legal remedies in child abuse and neglect. Pediatricians understand the challenges of health care delivery. The medical examiner knows the circumstances and causes of death. DCYF knows the complexity of monitoring the safety of children.

Teams approach the analysis of child fatalities systematically.<sup>3,4</sup> They start their review of deaths due to injuries by

- Knowing where and how often they occur;
- Understanding who is most at risk and why;
- Postulating effective interventions that might have immunized them or other children from

harm; and

- Understanding that injuries to children do not just happen at random but are predictable and understandable, and, therefore preventable.

The team need not design and implement the prevention activity, but the team is the catalyst of information and can be key in connecting with crucial resources and community partners.

The team can also foster accountability as well as recognize and reward community efforts.

### OPERATION OF THE RHODE ISLAND CHILD DEATH REVIEW TEAM

The RICDIRT is a multidisciplinary team that reviews childhood deaths to identify risk factors and trends, and to inform prevention efforts. [Table 1] The Team is not a peer review of agencies or organizations, or of medical practice. It examines systems issues and potential preventability of deaths, not the performance of individuals. In Rhode Island, all deaths under 18 years of age regardless of cause must be reported to the Medical Examiners

Table 1  
Agencies Represented by Rhode Island Child Death Review Team

⊙ Department of Health: Medical Examiners Office Division of Family Health Safe Rhode Island Violence & Prevention Program
⊙ Department of Children, Youth & Families
⊙ Pediatrician: American Academy of Pediatrics
⊙ Child Protection Program, Hasbro Children's Hospital
⊙ Department of Human Services
⊙ Brown University Department of Community Health
⊙ Law Enforcement : Naval Criminal Investigative Services Brown University Department of Public Safety
⊙ Pediatric Emergency Department
⊙ Injury Prevention Center, Rhode Island Hospital
⊙ Child Advocates Office
⊙ Office of Attorney General

Office [Gen laws 4-7(2e)]. This allows for a complete database of all child deaths.

Beginning with the review of child deaths in 2000, Rhode Island child death review has been a two-step process.<sup>5,6,7</sup> First, the RICDRT conducts initial reviews of child deaths. Second, the RICDRT conducts in-depth case reviews based on interests identified from the initial reviews..

The initial child death review process is as follows:

1) Prior to team review, the details of each death are abstracted by the National **Maternal and Child Health (MCH)** Center for Child Death Review. A trained data manager abstracts the information, including autopsy, police, hospital, and social service records. The information is entered into the Rhode Island Child Death Review database. Ultimately, Rhode Island will participate with 16 other states to pilot the MCH Bureau National Child Death Review Surveillance System. Computerization of data will then be conducted using web-based software supported by the MCH Bureau National Child Death Review Program that will also enable de-identified Rhode Island data to be combined with de-identified data from other states for the initial phase of a National Child Death Review Surveillance System.

2) At the time of the RICDRT review meeting, the history and autopsy findings for each death are presented from the Medical Examiner's case summary and from the abstracted information compiled from Medical Examiner investigator reports, police reports, medical records, child protective services records, and interviews with witnesses and other involved parties.

3) Team members then discuss the characteristics and circumstances of each death, and assess the potential for preventability (see below). If members request, scene and autopsy photographs are presented. If members wish additional information, RICDRT support staff will obtain it by the next meeting.

#### **ASSESSMENT OF POTENTIALLY PREVENTABLE DEATHS**

There is no common or national standard for the definition

of preventability; however, most of the states involved in the child review process have adopted a similar definition: A child's death is considered to be preventable if the community (education, legislation, etc.) or an individual (reasonable precaution, supervision, or action) could reasonably have done something that would have changed the circumstances that led to the child's death.<sup>5</sup>

The designation of preventable does not imply that the death was caused by child abuse or neglect, or could absolutely have been prevented, but that reasonable intervention(s) might have prevented the death. *Reasonable* is defined by taking into consideration the circumstances and resources. Reasonable interventions are considered to be sensible, prudent, and suitable under the circumstances; not extreme or excessive. A death may be considered potentially preventable at the individual level only, community level only, or both the individual and community level.

The RICDRT members discuss the degree of preventability of each death at both the individual and community level by asking what key risk factors allowed the death to occur. The RICDRT members then classify each death as one of the following:

*Definitely preventable* when the death could have in most cases been prevented with reasonable intervention.

*Probably preventable* when the same certainty that exists in the category of "definitely" does not exist.

*Probably not preventable* when the child might still have died even with reasonable intervention.

*Definitely not preventable* when the death would have occurred regardless of any and all attempts at intervention.

All members sign confidentiality statements before sharing information.

The second step in the RICDRT process is organizing the potentially preventable deaths into groups with similar circumstances. Using detailed, state-specific data on risk factors and circumstances surrounding child deaths, the RICDRT will begin the process of developing recommendations for community and individual-level action. Formal recommendations

will be developed by the RICDRT in conjunction with prevention experts as well as governmental, professional and community agencies, and other stakeholders. To the extent possible, RICDRT will utilize existing resources such as task forces and coalitions currently involved in prevention activities in order to coordinate RICDRT work with existing efforts.

#### **SUMMARY OF RHODE ISLAND CHILD DEATH REVIEW TEAM FINDINGS**

From the review of 2000-2002 child deaths, the RICDRT identified two areas in need of immediate prevention intervention: 1) deaths due to motor vehicle accidents, and 2) deaths of infants co-sleeping with adults or sleeping on structures not designed for infant use. These are reported in more detail in the associated article *Health by Numbers*.

Once the in-depth reviews of child deaths associated with infant co-sleeping and with motor vehicle accidents have been completed, other groups of potentially preventable deaths will be prioritized for review. At the initial reviews of child deaths, RICDRT members informally proposed a number of potential prevention strategies at the community and individual level for consideration. Some of these strategies are presented here to illustrate the interventions under discussion.<sup>4</sup>

##### **• Homicide**

- Examples of community-level action identified as having the potential to reduce homicides were the implementation of urban planning techniques to render neighborhoods less hospitable to gangs and drug traffickers, increased community policing, community involvement to increase neighborhood safety, and control of firearms.<sup>6,7</sup>
- Examples of individual-level action identified as having the potential to reduce homicides were individual's use of anger management techniques as well as increased parental supervision of children's activities and vigilance regarding weapon possession.
- *Child Abuse Homicide*
  - An example of community-